Wyoming Department of Health — Behavioral Health Division

TEAM SIGNATURE AND VERIFICATION FORM

Participant Name:	**Approved Budget (IBA):** $	**Case Manager:**	**CM NPI #:**
☐ **Annual Plan of Care**	**Plan Start Date:**	**Waiver:** ☐ ABI ☐ Comprehensive ☐ Child DD ☐ Supports	
☐ **Modification of an Approved Plan**	**Mod Effective Date:**	**Electronic form may be used in lieu of this section.**	

Service Code & Type	Provider Number (9-10 Digits)	Provider Name	Total Units Used (12 Months)	Service Rate (Dollars Per Unit)	Total Cost (For 12 Months)	*(Mod)* Units up	down
					$ 0.00	☐	☐
					$ 0.00	☐	☐
					$ 0.00	☐	☐
					$ 0.00	☐	☐
					$ 0.00	☐	☐
					$ 0.00	☐	☐
					$ 0.00	☐	☐
				Subtotal **$**	$0.00		

Proposed services under Self-Direction:	**Amount Proposed to Self-Direct through Fiscal/Employer Agent $**
	Total $ $0.00

Provider Verification. Each Provider on the plan shall review and sign this form in the space provided to acknowledge their agreement to all of the statements below. A copy of this agreement shall be distributed to all team members by the case manager when the plan is approved. If the plan is modified and a provider's units are changed, then this form shall be signed by the provider before the modification is submitted to the Division to verify agreement to the change on the plan.

Service Documentation. The provider(s) shall be responsible for developing the schedule or form to document the provision of services in accordance with the documentation requirements listed in Wyoming Medicaid Rules Chapter 45, Section 25. As of June 1, 2011, the schedule or tracking form is no longer submitted to the Division for approval before being used.

Objectives. Habilitation services shall provide routine learning opportunities for the participant with meaningful and measureable objectives. The objectives shall align with the person's assessed needs, personal goals, and be developed in accordance with the Documentation Standards, Objective and Schedule requirements in Wyoming Medicaid Rules Chapter 45.

Service reporting and responsibility of providers. Providers shall keep a detailed record of services rendered, reporting services provided, and reporting objective progress to the case manager by the 10th business day of the next calendar month.

Team Participation. I have participated in the development of this plan, either by submitting service summaries and/or by attending the team meeting.

Relative Disclosure. Any provider who is related to the participant shall disclose their relationship prior to service authorization.

Plan Approval. I understand that the Division has final approval of the plan, and if there are changes to the plan during the approval process, the case manager will notify all team members. I agree to implement the plan of care as approved by the Division.

Signature of Approval	Printed Name / Organization	Signature Date	Related to participant	Relationship / Service Provided	Approval given:
			☐	Participant	☐ In person ☐ by phone ☐ by email ☐ other: _____
			☐	Guardian	☐ In person ☐ by phone ☐ by email ☐ other: _____
			☐	Case Manager	☐ In person ☐ by phone ☐ by email ☐ other: _____
			☐		☐ In person ☐ by phone ☐ by email ☐ other: _____
			☐		☐ In person ☐ by phone ☐ by email ☐ other: _____
			☐		☐ In person ☐ by phone ☐ by email ☐ other: _____
			☐		☐ In person ☐ by phone ☐ by email ☐ other: _____
			☐		☐ In person ☐ by phone ☐ by email ☐ other: _____